

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-002440

STATE FILE NUMBER

Registration District No. 187 Primary Registration District No. 3040 Registrar's No. 15

DO NOT WRITE  
ON THIS STUB

AMENDED

1. PLACE OF DEATH a. COUNTY <u>LIVINGSTON</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>LIVINGSTON</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>CHILLICOTHE</u>		Length of stay in 1b <u>2 WEEKS</u>	c. CITY OR TOWN <u>CHILLICOTHE</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>CITY HOSPITAL</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>118 CLAY ST.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>MAUDE EDNA TITUS</u>			4. DATE OF DEATH Month Day Year <u>JANUARY 16, 1963</u>
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>8/28/76</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BOOK KEEPER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BANKING</u>	11. BIRTHPLACE (City and state or country) <u>PUGHMAN CO., MO.</u>
13a. FATHER'S NAME <u>EDWARD TITUS</u>		13b. MOTHER'S MAIDEN NAME <u>RACHEL SPEILMAN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		17. INFORMANT <u>MRS. MANN HOOVER</u> Address <u>610 E. 8th Court</u> <u>TRENTON MO.</u>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia Terminal</u> Conditions, if any, which gave rise to above cause (s), stating the underlying cause last: DUE TO (b) <u>Thrombosis of brain, R. arm + L leg</u> DUE TO (c) <u>Aneurysm of Abdominal Aorta</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>1 wk.</u> <u>8 years</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>Jan 14-54</u> to <u>Jan 16-63</u> and last saw her alive on <u>Jan 13-63</u> Death occurred at <u>4:00</u> A.M. on the date stated above, and to the best of my knowledge, from the causes stated.			
22. SIGNATURE (Degree or title) <u>Joseph A. Cascard M.D.</u>		22b. ADDRESS <u>Chillicothe, Mo.</u>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>BURIAL</u>		23b. DATE <u>1/18/63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>HARRIS CEMETERY</u>
24. FUNERAL DIRECTOR <u>NORMAN FUNERAL HOME: Chillicothe, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>Jan. 18, 1963</u>	
26. REGISTRAR'S SIGNATURE <u>Annalee Taylor</u>		27. DATE SIGNED <u>Jan 17-63</u>	

USE BLACK INK

OR

TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

INSTEAD OF

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

VS 300  
Rev. 4/59  
0595  
20595  
3  
4 1  
5 0  
6  
7 0  
8 2  
9451X  
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11  
12 1-0  
13 1-0

Date Taken to Dr. Conrad 1/16/63

Date Rec'd. from Dr. Conrad 1/17/63 1963

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed

*John P. Rodgers*

Licensed Embalmer No. 4963

P. O. Address CHILlicothe, MISSOURI

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.